

CRITERIA FOR PRIOR AUTHORIZATION

Topical Immunomodulators

PROVIDER GROUP: Pharmacy**MANUAL GUIDELINES:** The following drug(s) require prior authorization:
Crisaborole (Eucrisa®)
Pimecrolimus (Elidel®)
Tacrolimus (Protopic®)**CRITERIA FOR INITIAL APPROVAL:** (must meet all of the following)

- The patient must have a diagnosis of atopic dermatitis.
- Prescriber must attest that all medication-specific safety criteria, as defined in table 1, is met.
- One of the following must be met (a or b):
 - a. Patient must have experienced an inadequate response after a trial of a prescription strength topical corticosteroid, OR have a documented intolerance or contraindication to a prescription strength topical corticosteroids within the last 120-day period.
 - Prescriber must provide documentation of all previous medication trials. Documentation must include the medication name(s), trial date(s) and outcome(s) of the trial (i.e. inadequate response, intolerance or contraindication).
 - OR
 - b. Patient has atopic dermatitis on the face and prescriber has a concern with long-term steroid used on the face.

CRITERIA FOR RENEWAL:

- Prescriber must attest that the patient has received clinical benefit from continuous treatment with the requested medication.
- Prescriber must attest that all medication-specific safety criteria, as defined in table 1, continues to be met.

LENGTH OF APPROVAL: 6 months**TABLE 1. MEDICATION-SPECIFIC CRITERIA**

MEDICATION-SPECIFIC CRITERIA	
Elidel	• Patient must be ≥ 2 years of age
Eucrisa	• Patient must be ≥ 2 years of age
Protopic	• Patient must be ≥ 2 years of age for 0.03% strength • Patient must be ≥ 16 years of age for 0.1% strength

Drug Utilization Review Committee Director_____
Pharmacy Program Manager,
Kansas Health Policy Authority_____
Date_____
Date